STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE
HEALTH CARE SERVICE PLAN

QUARTERLY REPORTING FORM

FOR THE YEAR ENDING _____, _____

OF THE CONDITIONS AND AFFAIRS OF

DRAFT PLEASE SEND COMMENTS TO MYAMANAKA@DMHC.CA.GOV

(Name)

A Health Care Service Plan organized under the laws of the **STATE OF CALIFORNIA** made to the **DEPARTMENT OF MANAGED HEALTH CARE** pursuant to the laws thereof.

Date Incorporated or Organized: _____ Date Licensed as a HCSP: _____

Date Federally Qualified as an HMO: _____ Date Commenced Operations: _____

Mailing Address: _____

Address of Main Administrative Office: _____

Telephone Number: _____ Employer's ID Number: _____

Principal Location of Books and Records: _____

Plan Contact Person and Phone Number: _____

Financial Reporting Contact Person and Phone Number: _____

OFFICERS*

President: _____ Other Officers: _____

Secretary: _____ _____

Chief Financial Officer: _____ _____

DIRECTORS*

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

STATE OF: _____

COUNTY OF: _____

……..……..……, President, ……..……..…..……, Secretary,

……..…..……..……., Chief Financial Officer (or corresponding person having charge of the financial records of the HCSP) of ……., being duly sworn, each for himself, deposes and says that they are the above described officers of said Health Care Service Plan, and that, for the reporting person stated above, all of the herein assets were the absolute property of the said HCSP, free and clear from any liens or claims thereon, except as herein stated, and that these financial statements, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said HCSP as of the reporting period stated above, and of its income and deductions therefrom for the period reported, according to the best of their information, knowledge and belief, respectively.

……..…..…..……. President

…….. Secretary

……..…..Chief Financial Officer

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* Show full name (initials not acceptable) and indicate by sign (#) those officers and directors who did not occupy the indicated position in the previous statement.